

7319

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WILDOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1008 Camden Ave. PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>ACHTERKIRCHEN</u> Last <u>ACHTERKIRCHEN</u>		4. DATE OF DEATH Month <u>6</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/17/1876</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wholesale Liquor</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Fredrick K Achterkirchen</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>MRS. R. T. Pillsbury</u>		Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Senility</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>o. m.</u> <u>p. m.</u> Month <u>19</u> Day <u>19</u> Year <u>1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/1</u> <u>1959</u> to <u>6/4</u> <u>1959</u> , that I last saw the deceased alive on <u>6/4</u> <u>1959</u> , and that death occurred at <u>10:15</u> <u>P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>SALISBURY, MARYLAND</u> DATE SIGNED <u>AC Mitchell</u>			
ACTUAL SIGNATURE <u>AC Mitchell</u> M.D. <u>SALISBURY, MARYLAND</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Andrew C. Mitchell 211 MARYLAND AVE</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5/8/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson Co, SALISBURY, MD</u>		24a. REC'D BY REGISTRAR <u>JUN 9 '59</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>NORMANT, BAKER</u>			

TO HOSPITAL / ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL & FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

7373

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pittsville</b>		c. LENGTH OF STAY IN 1b <b>15 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pittsville</b>	
		d. STREET ADDRESS	
		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lester</b> Middle <b>Peter</b> Last <b>Baker</b>		4. DATE OF DEATH Month <b>6</b> Day <b>24</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 4, 1904</b>
9. AGE (In years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Poultry Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Owner</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Peter B aker</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b> <b>*****</b>		16. SOCIAL SECURITY NO. <b>216-16-7657</b>	
17. INFORMANT <b>Mrs. L. P. B aker</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the stomach &amp; metastases</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 1957</b> to <b>6/24</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6/23</b> , 19 <b>59</b> , and that death occurred at <b>7 A M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>DATE SIGNED</b> <b>Paul W. Beardsley</b> M.D. <b>6/26/59</b> PHYSICIAN'S NAME (Type) <b>E. M. Beardsley, M.D.</b> <b>207 Maryland Ave., Salisbury, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/26/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Farlow's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pittsville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co. Salisbury, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 2 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Knaus</b>			

*Dunge C. Nepp*

# CERTIFICATE OF DEATH

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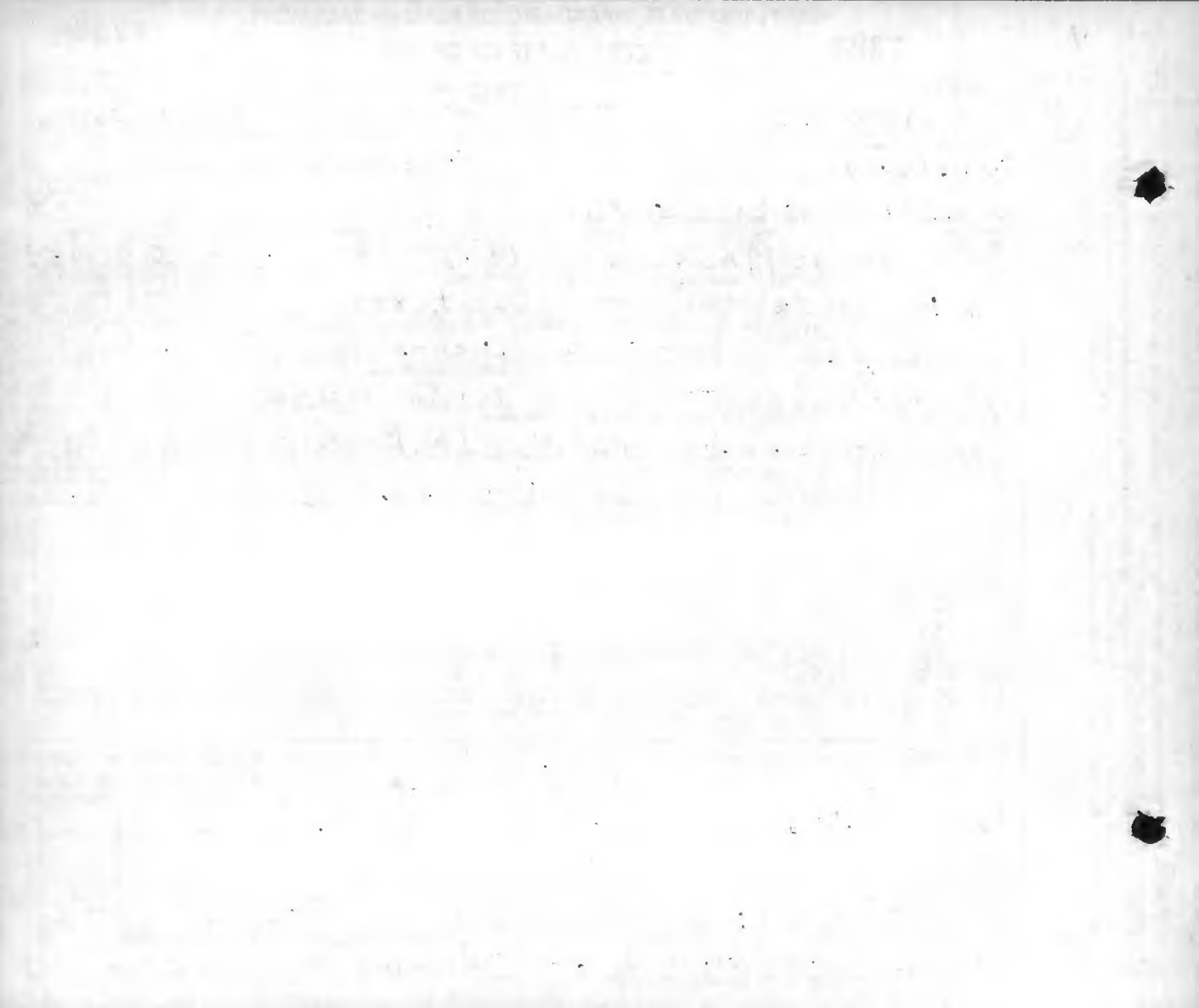
7320

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>2342-2</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES MANNION Barcliff</u>				4. DATE OF DEATH Month Day Year <u>June 29 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 4, 1897</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SAWYER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SELF-EMP.</u>		11. BIRTHPLACE (State or foreign country) <u>DURHAM NCK N.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>ALONZA BARCLIFF</u>				14. MOTHER'S MAIDEN NAME <u>KATIE EURE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>				16. SOCIAL SECURITY NO. <u>218-208735</u>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Degenerative Heart Disease</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>remission</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>6-29</u> , 19 <u>59</u> , to <u>6-29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-29</u> , 19 <u>59</u> , and that death occurred at <u>12:40 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William R. Ellis</u>				DATE SIGNED <u>6-29-59</u>			
PHYSICIAN'S NAME (Type)				ADDRESS (Street, city or town, state)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>7/2/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	
22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Orthur S. Huns</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
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VS A15 (4)  
 15M 9/58

7321

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07309

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chester</b> <b>17X-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Thomas</b> Last <b>Berry</b>		4. DATE OF DEATH Month <b>June</b> Day <b>15</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 19, 1887</b>
9. AGE (In years last birthday) yrs. <b>71</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OYSTERMAN</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wrightson Berry</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Ann Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO. <b>219-01-4525</b>	
17. INFORMANT <b>Hospital Records, Salisbury, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary insufficiency</b> DUE TO (c) <b>Arteriosclerotic cardiovascular disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 6, 1957</b> , to <b>June 15, 1959</b> , that I last saw the deceased alive on <b>June 15, 1959</b> , and that death occurred at <b>9:50 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>V. Juerman</b>		ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>V. Juerman, M.D.</b>		DATE SIGNED <b>6/16/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/21/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Chesapeake, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James B. Doherty, Esq., Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 23 '59</b>	
ADDRESS <b>Chesapeake, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7322

## CERTIFICATE OF DEATH

07310

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>9 mos.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>301 Holland Avenue</b>		d. STREET ADDRESS <b>301 Holland Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Elmer</b> Last <b>Carr</b>		4. DATE OF DEATH Month <b>June</b> Day <b>26th</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 29, 1884</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Signa Inspector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William S. Carr</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Eckels</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>717-07-9024</b>	
17. INFORMANT <b>Mattie S. Carr, Salisbury, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchial Asthma, Pulmonary Emphysema</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>David J. Gilmore</b>		ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>David J. Gilmore</b>		DATE SIGNED <b>6/26/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-29-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive</b>	22d. LOCATION (City, town, or county) (State) <b>Delmar, Delaware</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. S. Marvel Co. Delmar, Del.</b>		24a. REC'D BY REGISTRAR <b>JUL 9 59</b>	
ADDRESS <b>W. S. Marvel Co. Delmar, Del.</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Marvel</b>	

CERTIFICATE OF DEATH

1923

Blank certificate form with horizontal lines for text entry.



7323

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 9 Film G2447-20-59 et  
CERTIFICATE OF DEATH

07311

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>2Yr. 3mos. 8da.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Paul</b> Last <b>Chamberlain</b>		4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 10, 1903</b>
9. AGE (In years last birthday) <b>56 59/100</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rigger</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Reading, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph Chamberlain</b>		14. MOTHER'S MAIDEN NAME <b>Gertrude Staley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>181-03-4064</b>		16. SOCIAL SECURITY NO. <b>181-03-4064</b>	
17. INFORMANT <b>Hospital Records -- Salisbury, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recurrent CVA</b> <b>4431</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Bronchitis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 Hours</b> <b>Years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/29/57</b> , 19 <b>57</b> , to <b>6/26/</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6/26/</b> , 19 <b>59</b> , and that death occurred at <b>4:25 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>6/27/59</b>			
ACTUAL SIGNATURE <b>G. Kosmahly</b>		M.D. <b>Salisbury, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>G. Kosmahly</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/30/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Gilpin Manor Mem Park</b>	22d. LOCATION (City, town, or county) (State) <b>Elkton Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ralph E. Hicks, Elkton, Md</b>		24a. REC'D BY REGISTRAR <b>JUL 6 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7324

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07312

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	c. LENGTH OF STAY IN 1b <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>General</u>		d. STREET ADDRESS <u>Route 1 Box</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Conway</u> Last <u>Conway</u>		4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1894</u>
9. AGE (In years last birthday) <u>75</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Domestic</u>	11. BIRTHPLACE (State or foreign country) <u>Idaho</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John</u>		14. MOTHER'S MAIDEN NAME <u>2</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>NO</u>	17. INFORMANT <u>Gray Stewart</u> Address _____
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Syncope, Heart Failure</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Hypertension Heart Hypertension</u> DUE TO (c) <u>arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 24/15</u> 19 <u>59</u> to <u>6/1/59</u> 19 <u>59</u> , that I last saw the deceased alive on <u>6/1/59</u> 19 <u>59</u> , and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <u>Carrie Hearn</u> M.D. <u>226 N. Washington St.</u>			
PHYSICIAN'S NAME (Type) <u>CARRIE HEARN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-7-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Conway Lane</u>	22d. LOCATION (City, town, or county) (State) <u>Wicomico Md</u>
23 FUNERAL DIRECTOR'S SIGNATURE <u>Brooklyn Church</u>		24a. REC'D BY REGISTRAR JUN 9 '59 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hearn</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7325

# CERTIFICATE OF DEATH

07313

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admss on) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>1 day, 4 hrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mardela Springs</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Peninsula General Hospital</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <u>Riverton Road</u>	
3. NAME OF DECEASED (Type or print) <u>IRA</u> First <u>AtLee</u> Middle <u>Dashiell</u> Last		4. DATE OF DEATH Month <u>June</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 7 1959</u>
9. AGE (In years last birthday) yrs <u>1</u>		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>13</u> Hours <u>13</u> Min	
10a. USUAL OCCUPAT ON (Give kind of work done during most of working life, even if retired) <u>NEW BORN</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Thomas Fulton Dashiell</u>		14. MOTHER'S MAIDEN NAME <u>Novella Lee Elzey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Thomas Dashiell</u>		Address <u>Mardela Springs, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>712.5</u> DUE TO <u>Electrolysis fetalis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Prematurity (vlt 20g)</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2d</u> <u>2d</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 7</u> , 19 <u>59</u> , to <u>June 9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 9</u> , 19 <u>59</u> , and that death occurred at <u>2:00</u> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert SAUNDERS JR</u>		ADDRESS (Street, city, or town, state) <u>702 Camden Ave Salisbury, Md</u>	
DATE SIGNED <u>6/9/59</u>			
PHYSICIAN'S NAME (Type) <u>Robert SAUNDERS JR</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>June 9, 1959</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Mardela Springs Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Shirley F. Dashiell</u>		ADDRESS <u>Mardela Springs, Md</u>	
24a. REC'D BY REGISTRAR <u>June 10, 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur A. Hines</u>	
DATE <u>June 10, 1959</u>			

JUN 15 59



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7326

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

07314

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>806 Johnson St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BABY BOY Davis</u>		4. DATE OF DEATH Month Day Year <u>June 3 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jun. 3, 1959</u>
9. AGE (In years last birthday) <u>0</u> yrs		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>1</u> Min <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>	
13. FATHER'S NAME <u>Elton L. Davis</u>		14. MOTHER'S MAIDEN NAME <u>Mildred M. Tingle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr. Elton L. Davis (Father)</u>	
17. INFORMANT <u>806 Johnson St</u>		18. ADDRESS <u>Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO <u>Pulmonary atelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO (c) <u>Pneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Life</u> <u>Life</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19</u> to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Osborne Christensen</u>		ADDRESS (Street, city or town, state) <u>Peninsula Medical Bldg.</u>	
DATE SIGNED <u>Jun. 3, 1959</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Osborne Christensen</u>		<u>Salisbury, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jun. 6, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY &amp; COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
24a. REC'D BY REGISTRAR <u>Jun 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7327

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07315

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke CITY</u>	
c. LENGTH OF STAY IN 1b <u>3 DAYS</u>		d. STREET ADDRESS <u>Laurel St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Pennock General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALONZO THOMAS Davis</u>		4. DATE OF DEATH <u>June 9</u> 19 <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 9, 1883</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN DAVIS</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>214-12-6104A</u>	
17. INFORMANT <u>MRS ROBERT M. REVELLE, CRISFIELD, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 6, 1959</u> to <u>JUNE 9, 1959</u> , that I last saw the deceased alive on <u>June 8, 1959</u> , and that death occurred at <u>7:45</u> M, from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Thomas C. Hill Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Pine Bluff Road Salisbury Md</u>	
DATE SIGNED <u>6/9/59</u>			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6-11-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BAPTIST CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>POCOMOKE CITY, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold A. Watson</u>		ADDRESS <u>POCOMOKE CITY, MD.</u>	
24a. REC'D BY REGISTRAR <u>JUN 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	





7328

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

07316

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b>			
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>1211 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				e. STREET ADDRESS <b>Bush Chapel Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Alverta</b> Middle <b>Virginia</b> Last <b>Davis</b>				4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>1959</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 1, 1935</b>	9. AGE (In years last birthday) <b>23</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Aberdeen, Md.</b>		
13. FATHER'S NAME <b>Isiah Rogers Davis</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unk</b>			16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Hospital Records, Salisbury, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, right lower lobe</b> DUE TO (b) <b>Friedreich's cerebellar ataxia</b> DUE TO (c) <b>Atrophy of brain</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>  <b>Years</b>  <b>?</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour o m p m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>March 6</b> , 19 <b>56</b> , to <b>June 30</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 30</b> , 19 <b>59</b> , and that death occurred at <b>11:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>7/1/59</b>							
ACTUAL SIGNATURE <b>V. Juerman</b>			M D <b>Deer's Head State Hospital</b> <b>7/1/59</b>				
PHYSICIAN'S NAME (Type) <b>V. Juerman, M. D.</b>			<b>Salisbury, Md.</b>				
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/3/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>W.D. Calvary Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Aberdeen Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John E. Darrin</b>				ADDRESS <b>Aberdeen Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 6 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kinn</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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## CERTIFICATE OF DEATH

07317

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. STREET ADDRESS <u>N/A</u>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>T. R. A. Dennis</u>				4. DATE OF DEATH Month Day Year <u>June 27- 1959</u>			
5. SEX <u>male</u>		6 COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 10, 1897</u>	
9 AGE (In years last birthday) <u>62</u> yrs		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Leamon Dennis</u>				14. MOTHER'S MAIDEN NAME <u>Laura Ann Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16 SOCIAL SECURITY NO. <u>216-12-1646</u>			
				INFORMANT Address <u>Edith Dennis Hilland Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>JUNE 23<sup>rd</sup>, 1959</u> to <u>JUN 27<sup>th</sup>, 1959</u> , that I last saw the deceased alive on <u>JUNE 27<sup>th</sup>, 1959</u> , and that death occurred at <u>10:58</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William S. Ellis</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, or REMOVAL (Specify)		22b. DATE THEREOF <u>6/30/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Hope</u>		22d. LOCATION (City, town, or county) (State) <u>Hilland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peter Whaley</u> ADDRESS				24a. REC'D BY REGISTRAR <u>JUL 6 1959</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers—Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

7330

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07318

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Wicomico Hotel</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury, (Rural)</b>	
f. STREET ADDRESS <b>R.D.#3 (Marvel Road)</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELLA</b> Middle <b>LEE</b> Last <b>(BELL) DEVLIN</b>		4. DATE OF DEATH Month <b>June</b> Day <b>30th</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 29, 1902</b>
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months <b>9</b> Days <b>2</b>	IF UNDER 24 HRS. Hours <b></b> Min <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Mardela, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Unk</b>		14. MOTHER'S MAIDEN NAME <b>Hettie R. Hearn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b></b>	
17. INFORMANT <b>Mr. Preston N. Oliphant (Half-Brother)</b> <b>Marvel Rd. (R.D.#3) Salisbury, Maryland</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> <b>4/11</b> DUE TO <b>Rheumatic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b></b> INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b></b>	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) (County) (State) <b></b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>		DATE SIGNED <b>July 2 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 6, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Valhaller Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Milwaukee, Wisconsin</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR <b></b>		24b. REGISTRAR'S SIGNATURE <b>Earl L. Royer</b>	
DATE <b>JUL 6 1959</b>		<b></b>	





7331

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

07319

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>Pen Gen Hospital</b>		d. STREET ADDRESS <b>Ocean City Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JULIA</b> Middle <b>ANNA</b> Last <b>DUNTON</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>25</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 21, 1893</b>
9. AGE (In years last birthday) <b>66</b> yrs		IF UNDER 1 YEAR Months <b>5</b> Days <b>4</b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work at Home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Jersey City-New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Fredrick Kastner</b>		14. MOTHER'S MAIDEN NAME <b>Rose Leichmann</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>	
Mr <b>John T. Dunton (Husband)</b>		Address <b>Ocean City Blvd. Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Central embolus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ch. myocarditis</b> (c) <b>arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 12, 1959</b> to <b>6-25</b> , 1959, that I last saw the deceased alive on <b>6-24</b> , 1959, and that death occurred at <b>6:14</b> A. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>June 26 / 1959</b> DATE SIGNED			
ACTUAL SIGNATURE <b>Philip A. Insley</b>		M.D. <b>June 26 / 1959</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Philip A. Insley</b>		<b>116 E. Main St. Salisbury, Maryland</b>	
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 28 / 59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cape Charles Cemetery (Cape Charles, Virginia)</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 29 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur A. Evans</b>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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VS A15 (4)  
TSM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

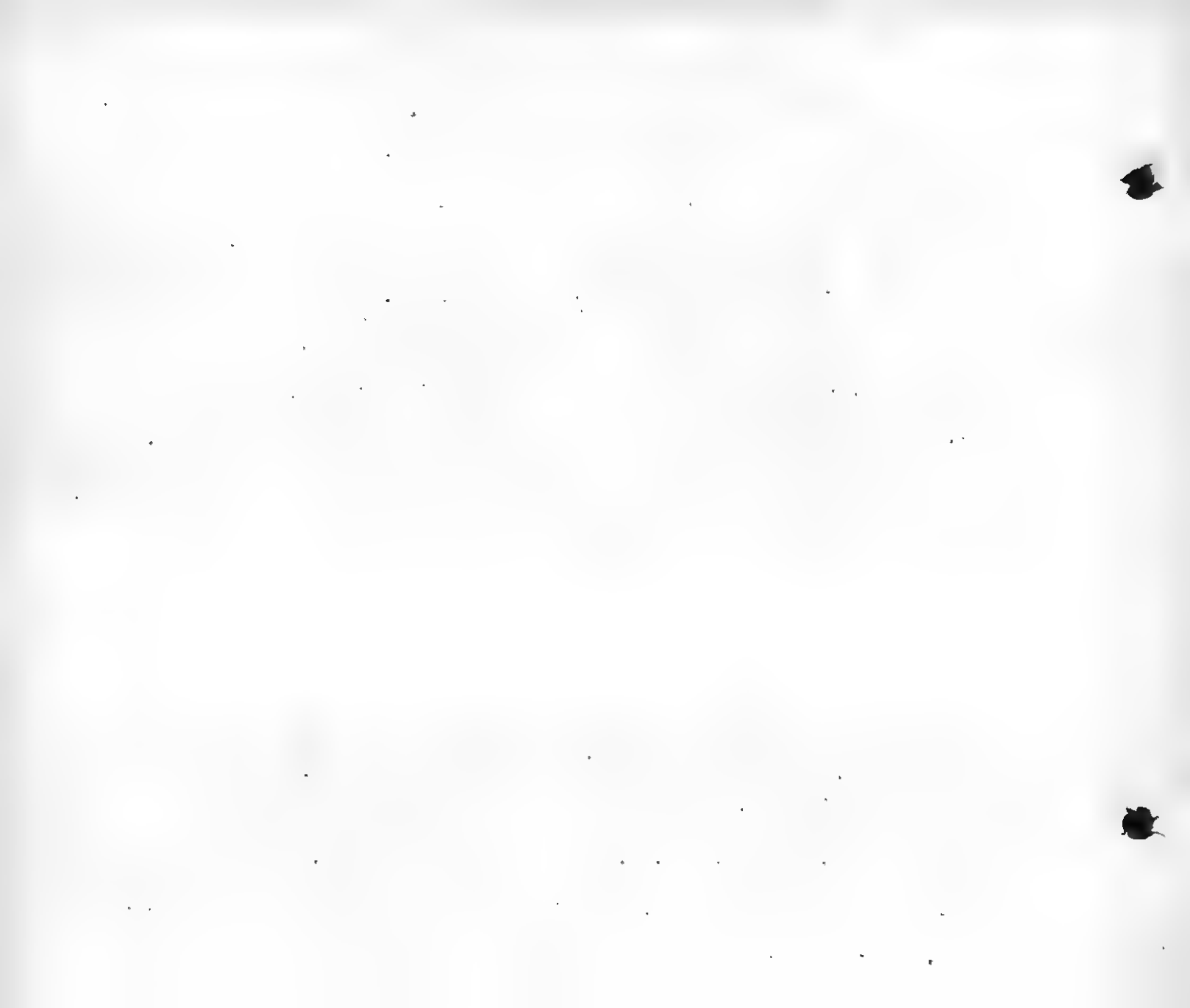
7332

CERTIFICATE OF DEATH

07320

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>231 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Vienna</b>		d. STREET ADDRESS <b>RFD</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>Tuttle</b> Last <b>Elliott</b>		4. DATE OF DEATH Month <b>June</b> Day <b>24</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 10, 1899</b>
9. AGE (In years last birthday) <b>59</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Cambridge, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Orlando Lee Elliott</b>		14. MOTHER'S MAIDEN NAME <b>Sallie Wheeler Vickers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Under No</b>		16. SOCIAL SECURITY NO. <b>Informant Address Hospital Records, Salisbury, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar pneumonia (left)</b> <b>526X</b> DUE TO <b>Bronchiectasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>?</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 5</b> , 19 <b>58</b> , to <b>June 24</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 24</b> , 19 <b>59</b> , and that death occurred at <b>3:45 AM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>6/24/59</b> ACTUAL SIGNATURE <b>L. V. Maldve</b> M.D. <b>Salisbury, Md.</b> PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>			
22a. BURIAL, CREMATION, or OTHER (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 26, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>East New Market Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>East New Market, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth J. Shuman</b> ADDRESS <b>Cambridge, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 29 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>John E. Evans</b>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

■ FUNERAL ■ DIRECTOR ■ TO ■ DEPUTY MEDICAL EXAMINER ■

or removal.

7333

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07321

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Selbyville Dela P.O. &amp; D.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>General Hospital</u>		d. STREET ADDRESS <u>178</u>	
3. NAME OF DECEASED (Type or print) <u>Letha</u> First <u>m</u> Middle <u>Evens</u> Last		4. DATE OF DEATH Month <u>6</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OF RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 30 1885</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>5</u> Hours <u>4</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Household</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Adolphus Watson</u>		14. MOTHER'S MAIDEN NAME <u>Annanda C. Richards</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>74-1-11111</u>	
17. INFORMANT <u>Wagel Lynch</u> Address <u>Selbyville Del. P.O. &amp; D.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> 904.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c) <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture neck left femur</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell at home</u>	
20c. TIME OF INJURY Month, Day, Year <u>6 8 1959</u> Hour (a.m. or p.m.) <u>9:15 P.M.</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Frankford</u> (County) <u>Del</u> (State) <u>Del</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial June 12, 1959</u>		22b. DATE THEREOF <u>June 12, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wheaton</u>		22d. LOCATION (City, town, or county) <u>Frankford</u> (State) <u>Delaware</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Watson &amp; Son</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Frank</u>	
ADDRESS <u>Frankford</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	
DATE <u>JUN 19 59</u>			



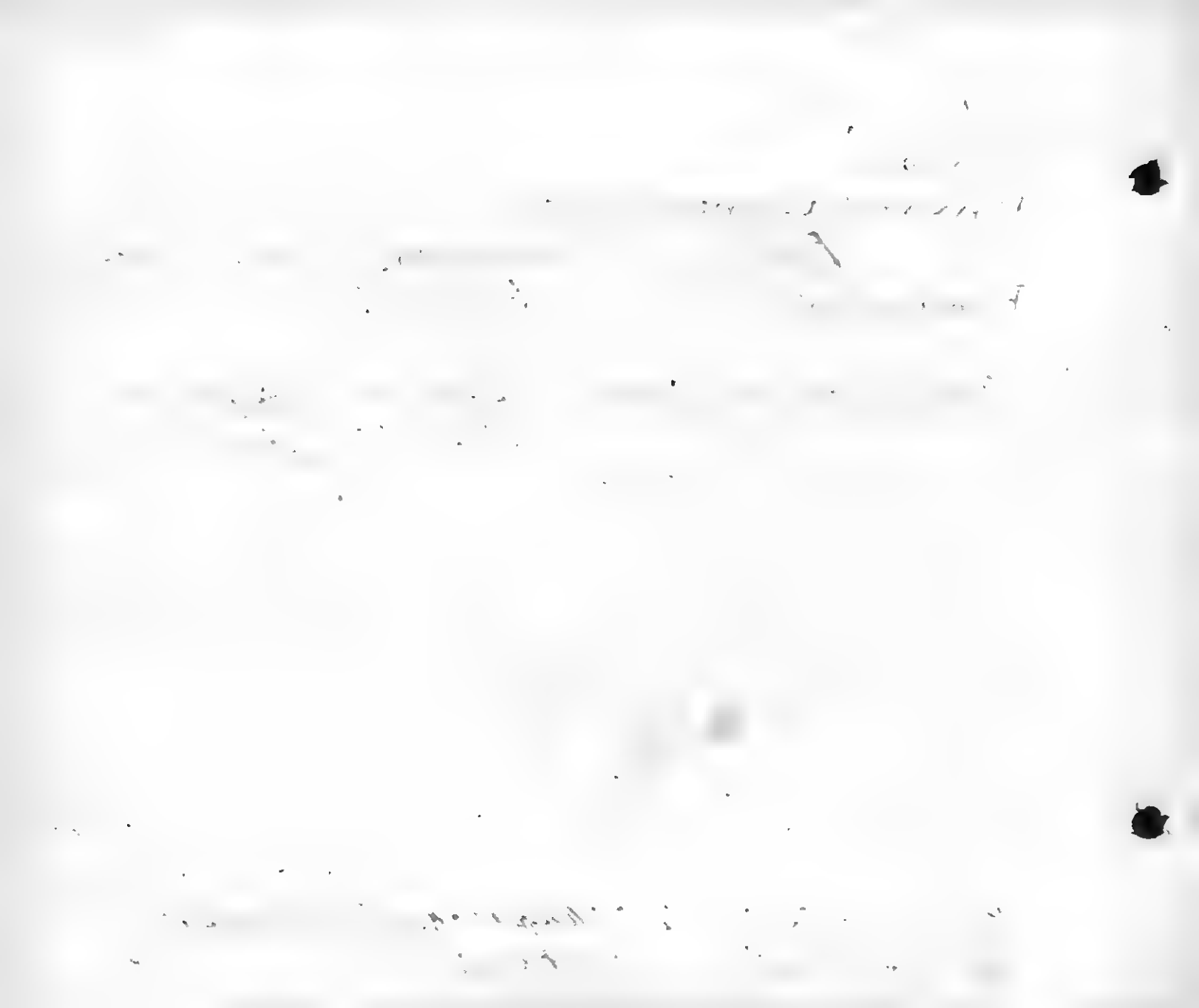


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
7334 Items 2, 11 Film G244 7-2-59 et									
CERTIFICATE OF DEATH									
Reg. Dist. No. 07322									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) ✓ a. STATE <u>Virginia</u> b. COUNTY <u>--</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Salisbury</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Onley</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>					d. STREET ADDRESS <u>P. O. Box 145</u>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Debbie Ferguson</u>					4. DATE OF DEATH <u>June 23-1959</u>				
5. SEX <u>Female</u>					6. COLOR OR RACE <u>White</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>6-23-19</u>				
9. AGE (In years last birthday) <u>3</u> yrs					10. IF UNDER 1 YEAR: Months <u>3</u> Days <u>5</u> Min. <u>5</u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>					12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME <u>Wm. Thos. Ferguson</u>					14. MOTHER'S MAIDEN NAME <u>Barbara Spiers</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Th. J. Ferguson</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u>									
DUE TO (b) <u>Prematurity (Birth wt 1385 gms)</u>									
DUE TO (c) <u>Approx 6 hours</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19 <u>59</u>									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>June 23, 1959</u> to <u>June 23, 1959</u> , that I last saw the deceased alive on <u>June 23, 1959</u> , and that death occurred at <u>5:30 P.M.</u> , from the causes and on the date stated above.									
22. I certify that I attended the deceased from <u>June 23, 1959</u> to <u>June 23, 1959</u> , that I last saw the deceased alive on <u>June 23, 1959</u> , and that death occurred at <u>5:30 P.M.</u> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Alfred C. Kolbs</u> M.D. <u>Medical Center</u> ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u> DATE SIGNED <u>6/24/59</u>									
PHYSICIAN'S NAME (Type) <u>Alfred C. Kolbs</u>									
22a. BURIAL, CREMATION, OR DISPOSAL (Specify) <u>Burial</u>									
22b. DATE THEREOF <u>6/25/59</u>									
22c. NAME OF CEMETERY OR CREMATORY <u>Thachapreague Thachapreague, Va.</u>									
22d. LOCATION (City, town, or county) (State)									
23. FUNERAL DIRECTOR'S SIGNATURE <u>Carlisle Williams</u> ADDRESS <u>ONANCOCK, Va.</u>									
24a. REC'D BY REGISTRAR <u>DATE JUN 29 '59</u>									
24b. REGISTRAR'S SIGNATURE <u>Carlisle Williams</u>									

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7335

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07323

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ton</u> <u>24</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>State's Road State Hospital</u>				d. STREET ADDRESS <u>27 S. Annapolis</u>			
3. NAME OF DECEASED (Type or print) First <u>Louisa</u> Middle <u>Ferguson</u> Last <u>Ferguson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1959</u>			
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 17, 1932</u>	9. AGE (In years last birthday) <u>77</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Bozman, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Faulkner</u>				14. MOTHER'S MAIDEN NAME <u>Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>Hospital records -- Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, hypostatic, bilateral</u> <u>199.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>Local Cell Carcinoma of neck w/local Hemorrhage.</u> metastases & <u>?</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 Days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis, General</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <u>2/23/59</u> 19 <u>59</u> to <u>6/5/59</u> 19 <u>59</u> that I last saw the deceased alive on <u>6/5/59</u> 19 <u>59</u> and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u> <u>6/5/59</u>							
ACTUAL SIGNATURE <u>G. Kosmahly</u>		M.D.		PHYSICIAN'S NAME (Type) <u>Berhard Kosmahly, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>June 9/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bozman</u>		22d. LOCATION (City, town, or county) (State) <u>Bozman</u> <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harrison Funeral Home</u>		ADDRESS <u>St Michaels</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Thomas</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MEDICAL CERTIFICATION



7336

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

07324

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Centreville</b>	
c. LENGTH OF STAY IN 1b <b>9 days</b>		d. STREET ADDRESS <b>RFD # 3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Elizabeth</b> Last <b>Fleetwood</b>		4. DATE OF DEATH Month <b>June</b> Day <b>5</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/31/1880</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Foster</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Ball</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Recurrent cerebral vascular accident</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>State after cerebral thrombosis with left hemiplegia</b> DUE TO (c) <b>Arteriosclerotic cardiovascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>4 weeks</b> <b>Years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, general</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 27</b> , 19 <b>59</b> , to <b>June 5</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 5</b> , 19 <b>59</b> , and that death occurred at <b>11 A.</b> M., from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>6/5/59</b>			
ACTUAL SIGNATURE <b>G. Kosmahly</b> M.D.		PHYSICIAN'S NAME (Type) <b>G. Kosmahly, M. D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JUNE 8</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>BLADES</b>		22d. LOCATION (City, town, or county) (State) <b>BLADES DEL.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward J. Lane</b>		ADDRESS <b>Church Hill Rd.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form IM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07325

7337

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>117 Jenkins St</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Fred Douglas Giddens Jr</u>		4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-22-46</u>
9. AGE (in years last birthday) <u>13</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School boy</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Fred R Giddens</u>		14. MOTHER'S MAIDEN NAME <u>Badie Walker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Badie Walker</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>dived into Johnsons Lake, failed to come up</u>	
20c. TIME OF INJURY Hour <u>4:25</u> o. m. <u>—</u> p. m. <u>—</u> Month, Day, Year <u>June 3, 1959</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>lake</u>	20f. (City or town) <u>Salisbury</u> (County) <u>Wicomico</u> (State) <u>Maryland</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Kendrick McCullough</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Kendrick McCullough</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>June 3, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-6-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greens Acres Cem</u>	22d. LOCATION (City, town, or county) <u>Salisbury md</u> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Barker M West</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>JUN 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

7338

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
18-24 11-243 6/10/59 cap  
**CERTIFICATE OF DEATH**

07326

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>6 wks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>304 N Blvo.</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Percy</u> Middle <u>RAYMOND</u> Last <u>GILBERT</u>				4. DATE OF DEATH Month <u>6</u> Day <u>8</u> Year <u>19 59</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/7/1878</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Stone Mill</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MRS J. W. PRICE, SAME.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Nervous System</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1955</u> to <u>6-8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6-8</u> , 19 <u>59</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Philip A. Insley</u> M.D.				DATE SIGNED <u>6-10-59</u>			
PHYSICIAN'S NAME (Type) <u>Philip A. Insley</u>				Salisbury, Wicomico County, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/11/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MARCELA CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MARCELA, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson Co. SALISBURY, MD</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

Norman T. Baker.



TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7339

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

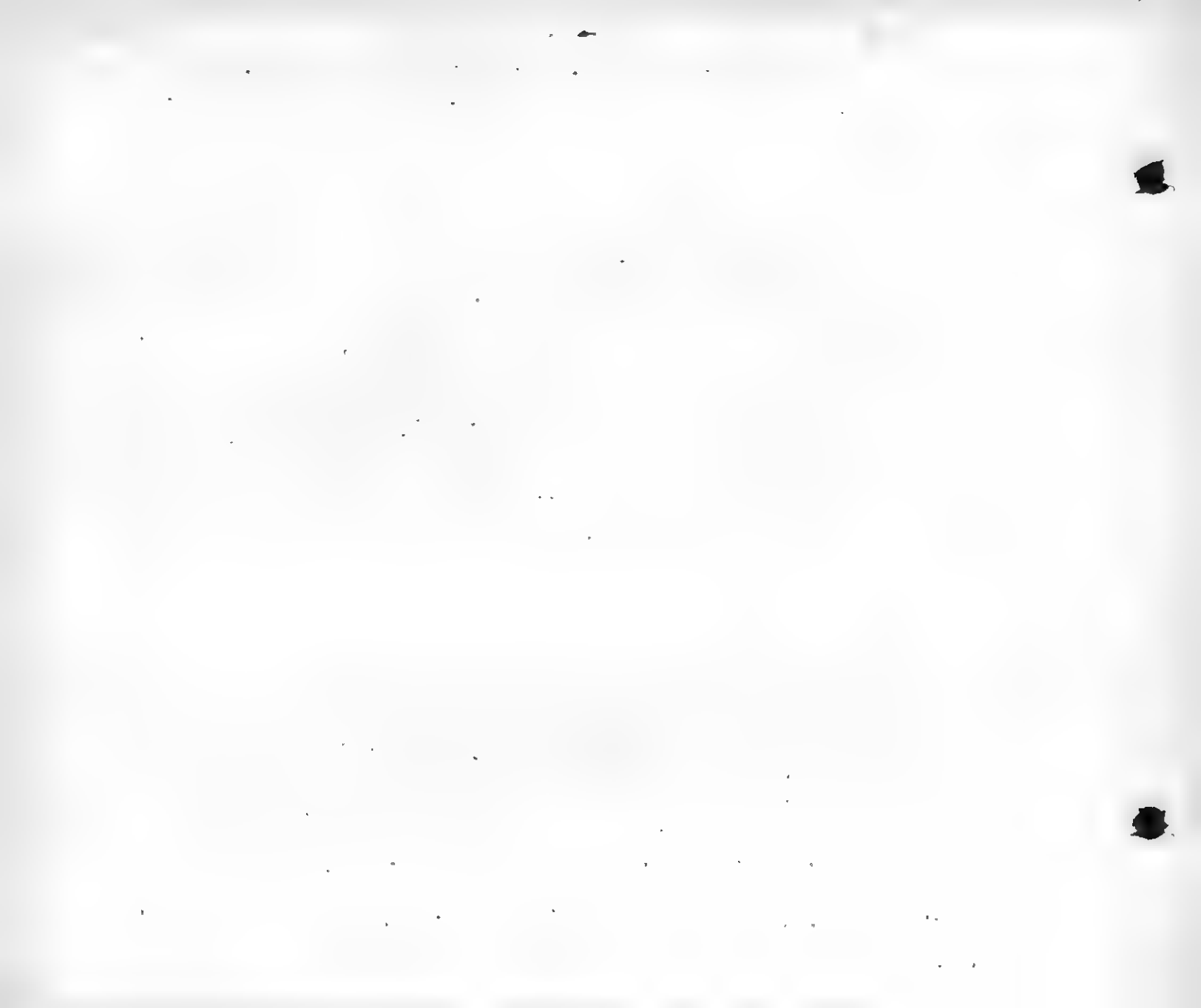
## CERTIFICATE OF DEATH

07327

Husband Late Wm. Truitt Gillis Died Jan. 26 1959

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Nicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>69 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		d. STREET ADDRESS <b>Spring Hill Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Agnes</b> Middle <b>Virginia</b> Last <b>Gillis</b>		4. DATE OF DEATH Month <b>June</b> Day <b>3</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 15, 1888</b>
9. AGE (In years last birthday) <b>70 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Salisbury, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Isaac Jones</b>		14. MOTHER'S MAIDEN NAME <b>Sally Crouch</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unk</b>		16. SOCIAL SECURITY NO. <b>Mr. Wilson Gillis (Son) Spring Hill Rd Hospital Records, Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriolar nephrosclerosis</b> <b>446X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized</b> DUE TO (c) <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchial pneumonia</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 26, 1959</b> , to <b>June 3, 1959</b> , that I last saw the deceased alive on <b>June 3, 1959</b> , and that death occurred at <b>1:50 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L. V. Maldve, M. D.</b>		ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>6/3/59</b>	
PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>		<b>Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jun. 6, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mardela Mem. Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Mardela, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>JUN 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>	



7340

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07328

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
c. LENGTH OF STAY IN TB <b>1 1/2 years</b>		d. STREET ADDRESS <b>1746 E. Chase Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Silas</b> Middle <b>Guider</b> Last <b>Guider</b>		4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/14/1915</b>
9. AGE (In years last birthday) <b>43 yrs.</b>		IF UNDER 1 YEAR Months <b>43</b> Days <b>43</b> Hours <b>43</b> Min. <b>43</b>	IF UNDER 24 HRS Months <b>43</b> Days <b>43</b> Hours <b>43</b> Min. <b>43</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>?</b>	11. BIRTHPLACE (State or foreign country) <b>?</b>
12. CITIZEN OF WHAT COUNTRY? <b>?</b>		13. FATHER'S NAME <b>Silas Guider</b>	
14. MOTHER'S MAIDEN NAME <b>Dora Turnipseed</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>?</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>?</b>		INFORMANT <b>Hospital Records</b> Address <b>?</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> DUE TO <b>Hypertensive arteriosclerotic cardiovascular</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>disease</b> DUE TO (c) <b>?</b>			INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan. 20</b> , 19 <b>58</b> , to <b>June 23</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 23</b> , 19 <b>59</b> , and that death occurred at <b>3:45 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>V. Juerman</b>		ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>6/23/59</b>	
PHYSICIAN'S NAME (Type) <b>V. Juerman, M. D.</b>		<b>Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal 6-26-59</b>	22b. DATE THEREOF <b>6-26-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Little Zion Baptist</b>	22d. LOCATION (City, town, or county) (State) <b>Columbia, S.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Randolph J. Collick</b>		24a. REC'D BY REGISTRAR <b>29 '59</b>	
ADDRESS <b>1412 E. Preston St.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

7341

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07331

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OCEAN CITY	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS BALTIMORE AVE	
3. NAME OF DECEASED (Type or print) First Middle Last Mae REEDER HASTINGS		4. DATE OF DEATH Month Day Year June 26 19 59	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH FEB 1, 1889
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) OHIO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FINLEY REEDER		14. MOTHER'S MAIDEN NAME unknown.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT MRS ELSHA HASTINGS		Address OCEAN CITY, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atketosis lungs</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Diaphragmatic hernia</u> (c) <u>Diaphragmatic hernia</u> DUE TO (c) <u>Diaphragmatic hernia</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma breast</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Philip A. Insley		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Philip A. Insley		6/26/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/28/59	
22c. NAME OF CEMETERY OR CREMATORY EVERGREEN		22d. LOCATION (City, town, or county) (State) BERLIN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Anna A. Burbage		ADDRESS Berlin Md.	
24a. REC'D BY REGISTRAR DATE JUN 30 '59		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

7342

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07332

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY in lb <b>12</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>333 Barclay St</b>		d. STREET ADDRESS <b>333 Barclay St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SAMUEL</b> Middle <b>JAMES</b> Last <b>HASTINGS</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>13th</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 7, 1876</b>
9. AGE (In years last birthday) <b>82 yrs.</b>		IF UNDER 1 YEAR Months <b>82</b> Days <b>82</b> Hours <b>82</b> Min. <b>82</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Railroad Man</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>R.D.# Salisbury, Md</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Peter Edward Hastings</b>		14. MOTHER'S MAIDEN NAME <b>Lillie Boyce</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Mr. Clayton J. Hastings (Brother)</b> <b>333 Barclay St. Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>163X</b> DUE TO <b>Emphysema of Lung</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>1 yr</b> (b) <b>Emphysema of Lung</b> (c) <b>Emphysema of Lung</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Earl L. Royer</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. Earl L. Royer</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>June 15 /1959</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jun. 17, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 16 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	



7343

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07329

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Laversee</b> Middle <b>Hemphill</b> Last <b>Hemphill</b>		4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 21, 1905</b>
9. AGE (In years last birthday) <b>54</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Gaffney, S. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Montgomery</b>		14. MOTHER'S MAIDEN NAME <b>Jefferson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Unk</b>		16. SOCIAL SECURITY NO. <b>Informant</b> Address <b>Hospital Records, Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recurrent cerebral thrombosis</b> <b>552X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic cardiovascular disease, decompensated</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 12</b> , 19 <b>51</b> , to <b>June 10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 10</b> , 19 <b>59</b> , and that death occurred at <b>7:20PM</b> , from the causes and on the date stated above ADDRESS (Street city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>6/11/59</b>			
ACTUAL SIGNATURE <b>V. Juerman</b> M.D. <b>Deer's Head State Hospital</b>		DATE SIGNED <b>6/11/59</b>	
PHYSICIAN'S NAME (Type) <b>V. Juerman, M. D.</b>		<b>Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-15-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>mt Calvary</b>		22d. LOCATION (City, town, or county) (State) <b>md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George S. Kelson</b> ADDRESS <b>1348 N. Calhoun St</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 15 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Clara S. Kraus</b>	

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained at the hospital or attending physician on.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

12. 11. 1911

07333

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>414 LAKE ST.</u>			
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Hicks</u> Last <u>Hicks</u>				4. DATE OF DEATH Month <u>June</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 15 1898</u>	9. AGE (In years last birthday) <u>60</u> yrs	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>?</u>			14. MOTHER'S MAIDEN NAME <u>?</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service)			16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>J. B. Hopton</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/24/59</u> 19 <u>59</u> , to <u>6/9/59</u> 19 <u>59</u> , that I last saw the deceased alive on <u>6/9/59</u> 19 <u>59</u> , and that death occurred at <u>1:45</u> M, from the causes and on the date stated above							
ACTUAL SIGNATURE <u>PC Mitchell</u>				ADDRESS (Street, city or town, state) <u>2113 Maryland Ave. Salisbury Md</u>			
PHYSICIAN'S NAME (Type) <u>PC Mitchell</u>				DATE SIGNED <u>6/11/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6-12-59</u>		<u>Wicomico Bd</u>		<u>Salisbury</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Barker M. Clark</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>JUN 15 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7345

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chestertown</b>			
c. LENGTH OF STAY IN It <b>1 day</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				d. STREET ADDRESS <b>219 Queen Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Ida</b> Middle <b>Homley</b> Last <b>Homley</b>				4. DATE OF DEATH Month <b>June</b> Day <b>11</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 22, 1893</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.		IF UNDER 24 HRS Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Kent Co., Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>James Yorker</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Derry</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>				16. SOCIAL SECURITY NO. <b>Informant</b>			
17. ADDRESS <b>Hospital Records, Salisbury, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hypertensive arteriosclerotic heart disease, decompensated.</b> DUE TO (b) <b>Arteriosclerosis, general</b> DUE TO (c) <b>Arteriosclerosis, general</b>							INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Glomerulonephritis</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 10</b> , 19 <b>59</b> , to <b>June 11</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 11</b> , 19 <b>59</b> , and that death occurred at <b>1:40 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>V. Juerman</b>				ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b>			
PHYSICIAN'S NAME (Type) <b>V. Juerman, M. D.</b>				DATE SIGNED <b>6/11/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>6/15/59</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Pomona Cem.</b>				22d. LOCATION (City, town or county) (State) <b>near - Chestertown, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth Waddy</b>				ADDRESS <b>Chestertown, Md.</b>			
24a. REC'D BY REGISTRAR <b>DATE JUN 17 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			

Handwritten text, possibly a signature or date, located in the lower right quadrant of the page.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/58

7346

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07335

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <b>Oriole</b>			
c. LENGTH OF STAY IN 1b <b>117 days</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Hughes</b> Last <b>Hughes</b>				4. DATE OF DEATH Month <b>June</b> Day <b>1</b> Year <b>19 59</b>			
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 9, 1877</b>		9. AGE (In years last birthday) <b>81</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>St. Peters District</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Benjamin F. Hughes</b>				14. MOTHER'S MAIDEN NAME <b>Priscilla Willing</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unk</b>		16. SOCIAL SECURITY NO.		INFORMANT <b>Hospital Records, Salisbury, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial insufficiency</b> <b>600.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic pyelonephritis</b> DUE TO (c) <b>Old brain injury</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b>  <b>Years</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Old brain injury</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 4, 1959</b> , to <b>June 1, 1959</b> , that I last saw the deceased alive on <b>June 1, 1959</b> , and that death occurred at <b>3:10AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>L. V. Maldve, M. D.</b>		M.D. <b>Deer's Head State Hospital</b>		ADDRESS (Street, city or town, state)		DATE SIGNED <b>6/1/59</b>	
PHYSICIAN'S NAME (Type)		<b>Salisbury, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/3/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oriole</b>		22d. LOCATION (City, town, or county) (State) <b>Oriole Ind.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James Herman Princean</b>				ADDRESS <b>Princean</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 8 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7347

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07330

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>155 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Henry</b> Last <b>James</b>		4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 19, 1873</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months <b>85</b> Days <b>85</b> Hours <b>85</b> Min. <b>85</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Chance, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Theodore James</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO. <b>Unk</b>	
17. INFORMANT <b>Hospital Records, Salisbury, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary insufficiency with acute decompensation</b> 420.1 DUE TO Condit ons, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease with residual right hemiplegia</b> DUE TO (c) <b>Arteriosclerotic cardiovascular disease with residual right hemiplegia</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b> <b>Yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Amaurosis of right eye</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 26</b> , 19 <b>59</b> , to <b>June 30</b> , 19 <b>59</b> that I last saw the deceased alive on <b>June 30</b> , 19 <b>59</b> , and that death occurred at <b>2:00 P.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Deer's Head State Hospital</b> DATE SIGNED <b>6/30/59</b>			
ACTUAL SIGNATURE <b>G. Kosmahly, M.D.</b>		PHYSICIAN'S NAME (Type) <b>G. Kosmahly, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-2-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Chance, Som. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leroy G. Webster, Deal Island, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 7 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7348

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07336

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN 1b <b>6 weeks</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springhill Sanitarium, Inc.</b>		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Jesterville,</b> d. STREET ADDRESS <b>Maryland.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Mary W. Jester</b>		4. DATE OF DEATH Month Day Year <b>June 20, 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 20, 1873</b>
9. AGE (In years last birthday) <b>86</b> yrs		10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Wicomico Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Rufus Ingersoll</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Jane Rencke</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Rachel Hilber, Tulsa, Oklahoma</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. _____ Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 19 54 to 6-20-59</b> , 19____, that I last saw the deceased alive on <b>June 20, 19 59</b> , and that death occurred at <b>11 A. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>207 Maryland Ave., Salisbury, Md.</b> DATE SIGNED <b>6/22/59</b>			
ACTUAL SIGNATURE <b>Earl Beardsley</b>		M. D. <b>207 Maryland Ave., Salisbury, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Earl Beardsley</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/24/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Jesterville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. H. W. P. B. Bivulve, Maryland</b>		ADDRESS	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	



1

07337

7349

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Wicomico</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Somerset</u>	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>since 6/15/59</u>		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Maryland</u>				STREET ADDRESS (If rural give location) <u>RFD #1, Box #1</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Jacquillen</u> <u>Olevia</u> <u>Johnson</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>June</u> <u>16</u> <u>19 59</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>Colored</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Single</u>	<b>8. DATE OF BIRTH</b> <u>Oct. 6, 1932</u>	<b>9. AGE last birthday</b> <u>26</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Marion Station, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Stanley Johnson</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mildred Davis</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>213-30-4353</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Records of Pine Bluff State Hospital</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) _____							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>21b. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>June 15</u> , 19 <u>59</u> , <b>to</b> <u>June 16</u> , 19 <u>59</u> , <b>that I last saw the deceased alive on</b> <u>June 16</u> , 19 <u>59</u> , <b>and that death occurred at</b> <u>3:25 PM</u> , <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Edward J. Retelien, M.D.</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Salisbury, Md.</u>		<b>DATE SIGNED</b> <u>6/16/59</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>June 21-59</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Branch Cemetery</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Marion Som. Md.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>W. J. ...</u>		<b>REGISTRAR'S SIGNATURE</b> <u>W. J. ...</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Charles H. Wood Mason, Md.</u>			
<b>DATE</b> <u>JUN 23 '59</u>							

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 153 1-55 104





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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08507

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Preston</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		d. STREET ADDRESS <b>Route 2</b>	
3. NAME OF DECEASED (Type or print) First <b>Alberta</b> Middle <b>J.</b> Last <b>Jones</b>		4. DATE OF DEATH Month <b>June</b> Day <b>27</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 22, 1887</b>
9. AGE (In years last birthday) <b>71</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unk.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unk.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland (Dorchester Co.)</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James Strawberry</b>		14. MOTHER'S MAIDEN NAME <b>Sara Jane (last name unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Hospital Records - Salisbury, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subtotal Occlusion of right and both branches of Left coronary Arteries</b> DUE TO (b) <b>Arteriosclerotic Heart disease</b> DUE TO (c) <b>Arteriosclerotic Heart disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval between onset and death</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/17/</b> 19 <b>59</b> , to <b>6/27/</b> 19 <b>59</b> , that I last saw the deceased alive on <b>6/27/</b> 19 <b>59</b> , and that death occurred at <b>1:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>6/27/59</b>			
ACTUAL SIGNATURE <b>G. Kosmahly</b> M.D.		DATE SIGNED <b>6/27/59</b>	
PHYSICIAN'S NAME (Type) <b>G. Kosmahly, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 2, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Washington Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Near Furlock, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Hampton &amp; Son, Federalsburg Md.</b>		24a. REC'D BY REGISTRAR <b>DATE JUL 10 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7351

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 14 Film G-44 7-20-59 et  
CERTIFICATE OF DEATH

07338

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula Gen. Hospital</u>				d. STREET ADDRESS <u>Parsonsbury</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Jones</u> Last <u>Jones</u>				4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1959</u>			
5. SEX <u>m</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-29-1898</u>	9. AGE (In years lost birthday) <u>60</u> yrs	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager, Seaside Station</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gasoline</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John J. Jones</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-09-4622</u>			
17. INFORMANT <u>Esther Jones, Parsonsbury</u>				Address <u>Parsonsbury</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cor Pulmonale</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>emphysema</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>15 yr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 59</u> to <u>June 29, 1959</u> that I last saw the deceased alive on <u>June 29, 1959</u> and that death occurred at <u>1:40 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul H. Beaudry</u> M.D.				DATE SIGNED <u>6/29/59</u>			
PHYSICIAN'S NAME (Type) <u>Paul H. Beaudry</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>7-2-59</u>		<u>Parsonsbury</u>		<u>Parsonsbury MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Marmelstein - Baltimore</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
				DATE <u>JUL 6 '59</u>		<u>Arthur L. Hines</u>	



7353

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

07339

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>115 Walnut St</b>		d. STREET ADDRESS <b>115 Walnut St</b>	
3. NAME OF DECEASED (Type or print) First <b>MARGARET</b> Middle <b>M.</b> Last <b>LARMAR</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>30</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 14, 1873</b>
9. AGE (In years last birthday) <b>85</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>George Bremer</b>		14. MOTHER'S MAIDEN NAME <b>Anna Dorothy Boelingher</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Miss. Lucretia Bremer (Niece)</b> Address <b>115 Walnut St Salisbury, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/23/59</b> to <b>6/30/59</b> , that I last saw the deceased alive on <b>6/29/59</b> , and that death occurred at <b>4:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>July 1 / 1959</b> ACTUAL SIGNATURE <b>Earl M. Beardsley</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. Earl M. Beardsley</b> <b>207 Maryland Ave. Salisbury, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 2, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR <b>JUL 6 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. King</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7352

Item 8, Film G244, 6/10/59 fcy

CERTIFICATE OF DEATH

07340

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			
c. LENGTH OF STAY IN 1b <b>1 wk</b>				d. STREET ADDRESS <b>215 W. Philadelphia Ave.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>B. LANCHE EVANS LARMORE</b>				4. DATE OF DEATH Month Day Year <b>6 13 19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1881</b>		9. AGE (In years last birthday) <b>77</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State of foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Jerome Evans</b>				14. MOTHER'S MAIDEN NAME <b>Lucy Willing</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>E. Hugh Larmore</b> Address <b>Salisbury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)							INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>19 45</b> to <b>6-13</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>12</b> , and that death occurred at <b>7:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Salisbury, Md.</b> DATE SIGNED <b>6-15-59</b>							
ACTUAL SIGNATURE <b>Philip A. Insley</b> M.D.				PHYSICIAN'S NAME (Type) <b>Philip A. Insley, M.D.</b> <b>E. Main St., Salisbury, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/15/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hill &amp; Johnson Co.</b> ADDRESS <b>Salisbury, Maryland</b>				24a. REC'D BY REGISTRAR <b>JUN 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Thomas</b>	





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 1, 2, and 3 may be retained for your files. File pages 1, 2, and 3 with the registrar prior to burial, cremation, or removal.

VS. A13ME(5)  
SM 9/55

7354 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 07341  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>12</b> <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		e. STREET ADDRESS <b>300 Newton Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Earl</b> Middle <b>Graham</b> Last <b>Lewis</b>		4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 9, 1914</b>
9. AGE (In years last birthday) <b>45</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck driver</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John Lewis</b>	
14. MOTHER'S MAIDEN NAME <b>Edna Waller</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WW II</b>	
16. SOCIAL SECURITY NO. <b>220-01-9350</b>		17. INFORMANT <b>Mrs. Earl G. Lewis</b> Address <b>300 Newton Street Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Casualty + thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Philip A. Insley</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Philip A. Insley</b>		DATE SIGNED <b>6-20-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/22/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thomas H. Walker</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 23 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>C. H. H. H.</b>			



7355

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Queen Anne's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Grasonville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Marian</b> Middle <b>Hodges</b> Last <b>Little</b>		4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 12, 1905</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday) <b>54 yrs</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Queen Anne Co., Md.</b>	
13. FATHER'S NAME <b>Daniel Deaton</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Mackey</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>	
16. SOCIAL SECURITY NO. <b>Unk</b>		INFORMANT Address <b>Hospital Records, Salisbury, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Glomerulonephritis, chronic</b> DUE TO (c) <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>23 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma of uterus and cerebral thrombosis with rt. hemiplegia</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 25</b> , 19 <b>59</b> , to <b>June 17</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 17</b> , 19 <b>59</b> , and that death occurred at <b>4:55 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>V. Juerman</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>Deer's Head State Hospital 6/17/59</b>	
PHYSICIAN'S NAME (Type) <b>V. Juerman, M. D.</b>		<b>Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-20-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Grasonville, Md.</b>		22d. LOCATION (City, town, or county) (State) <b>Grasonville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James B. Ashell, Easton, Md.</b>		ADDRESS <b>Easton, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 18 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Thomas</b>	



7374

CERTIFICATE OF DEATH

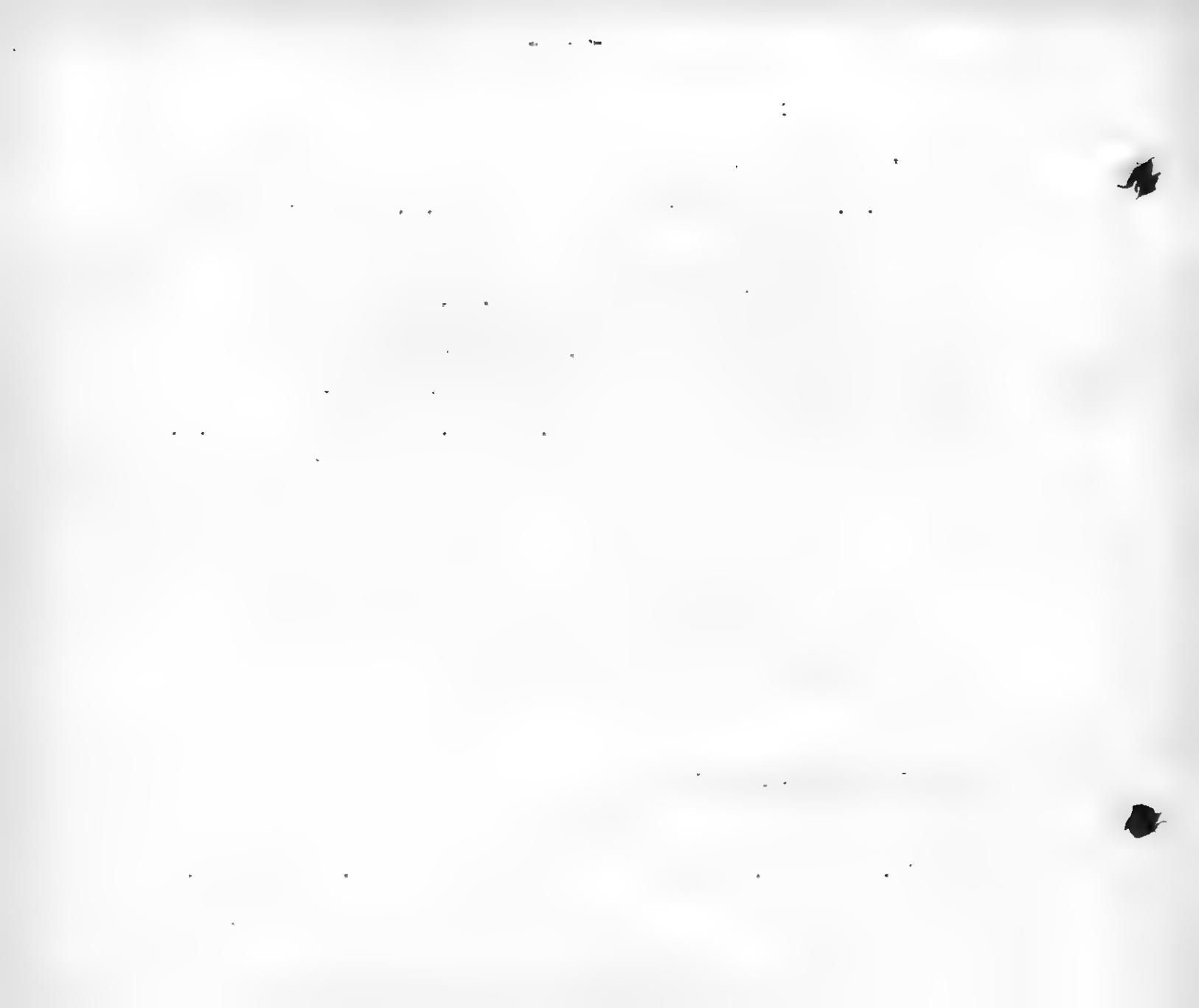
07343

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admision) a STATE <b>Maryland</b> b COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury (Rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury (Rural)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.# 4 (At Home)</b>		d. STREET ADDRESS <b>R.D.# 4 (Snow Hill Rd)</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MABEL</b> Middle <b>HILDA</b> Last <b>MALONE</b>		4. DATE OF DEATH Month <b>June</b> Day <b>13th</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 26, 1905</b>
9. AGE (In years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months <b>54</b> Days <b>13</b> Hours <b>13</b> Min <b>13</b>	IF UNDER 24 HRS Months <b>54</b> Days <b>13</b> Hours <b>13</b> Min <b>13</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary-Clerks Office-Wico Co.Court House)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Salisbury, Md</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Albert Fooks</b>		14. MOTHER'S MAIDEN NAME <b>Rosa Calloway</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Mr. Alex G. Malone (Husband) R.D.#4 (Snow Hill Road) Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Papillary Adenocarcinoma</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>4-19-1954</b> to <b>6-13-1959</b> that I last saw the deceased alive on <b>6-13-59</b> , 19 <b>59</b> , and that death occurred at <b>8:40 P</b> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>211 Maryland Ave. Salisbury, Maryland</b>	
ACTUAL SIGNATURE <b>Dr. Andrew C. Mitchell</b>		DATE SIGNED <b>June 15-1959</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Andrew C. Mitchell</b>		<b>Maryland Ave. Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 16, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>C. J. P. Hall</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7356

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

07344

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY, <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>		✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM DALE</u> Middle <u>MARTIN</u> Last <u>MARTIN</u>				4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 5 1959</u>	9. AGE (In years last birthday) <u>— yrs.</u>	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS Hours <u>—</u> Mins <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>ROBERT LOUIS MARTIN</u>				14. MOTHER'S MAIDEN NAME <u>SHIRLEY DAVIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MR. R. J. MARTIN</u> Address <u>Ocean City, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Aspiration</u> DUE TO <u>Perinatal Hypoxia due to Premature Separation of Placenta</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prematurity Birth wt 1725 gms</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>—</u> a. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/3/59</u> 19 <u>59</u> to <u>6/5/59</u> 19 <u>59</u> that I last saw the deceased alive on <u>6/4/59</u> 19 <u>59</u> and that death occurred at <u>22M</u> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Alfred C. Kolls</u> M.D.							
PHYSICIAN'S NAME (Type) <u>—</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/6/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BUCKINGHAM</u>		22d. LOCATION (City, town, or county) (State) <u>BELVIN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u>				ADDRESS <u>Belvin Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 9 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>			

2082273XV6





7357 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 CERTIFICATE OF DEATH

07345

Reg. Dist No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				e. STREET ADDRESS <u>Cedar Lane</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Kenneth</u> First Middle Last				4. DATE OF DEATH <u>MASON</u> Month <u>JUNE</u> Day <u>28</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 29, 1958</u>	AGE (In years last birthday) <u>8</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>8</u> Hours <u>8</u> Min.	IF UNDER 24 HRS Days <u>8</u> Hours <u>8</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Salisbury, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Benny Mason</u>				14. MOTHER'S MAIDEN NAME <u>Doris Miles</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown, (If yes, give year or dates of service))		16. SOCIAL SECURITY NO <u>—</u>		INFORMANT <u>Benny Mason - Salisbury, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metabolic Acidosis - profuse and irreversible</u> DUE TO <u>dehydration and shock</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Gastroenteritis - Non-specific.</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> Month, Day Year a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 27, 1959</u> , to <u>June 28, 1959</u> , that I last saw the deceased alive on <u>June 28, 1959</u> , and that death occurred at <u>11 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Alfred C. Koller</u> M.D.				ADDRESS (Street, city or town, state) <u>Medical Center, Salisbury, Md</u>			
PHYSICIAN'S NAME (Type) <u>Alfred C. Koller</u>				DATE SIGNED <u>6/28/59</u>			
22a. BURIAL CREMATION, (Specify) <u>Buried</u>		22b. DATE THEREOF <u>7-1-59</u>		22c. NAME OF CEMETERY OR CREMATOR <u>West Park Office</u>		22d. LOCATION (City, town, or county) (State) <u>Stomach Co.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Booke W. Welch</u>				24a. REC'D BY REGISTRAR DATE <u>JUL 7 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07346

7375

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>				c. LENGTH OF STAY IN 1b <b>63 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RD. 3</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lillian</b> Middle <b>Mexico</b> Last <b>Nichols</b>				4. DATE OF DEATH Month <b>June</b> Day <b>29</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 28, 1895</b>	
9. AGE (In years last birthday) <b>63 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Louis A. Reddish</b>				14. MOTHER'S MAIDEN NAME <b>Mary Hearn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Thomas Nichols, Delmar, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Congestive Cardiac Failure</b> DUE TO <b>Hypertension Cardio Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetes</b> (c) <b>Diabetes</b>							INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>18 yrs</b> <b>22 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 1946</b> to <b>June 29, 1959</b> , that I last saw the deceased alive on <b>June 29, 1959</b> , and that death occurred at <b>Delmar, Md.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>S. H. Lynch</b>				DATE SIGNED <b>June 29, 59</b>			
PHYSICIAN'S NAME (Type) <b>S. H. Lynch</b>				ADDRESS (Street, city or town, state) <b>Delmar Del</b>			
22a. BURIAL, CREMATION, OR OTHER (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7-2-59</b>		22c. NAME OF CEMETERY OR REPOSITORY <b>Mt. Olive</b>		22d. LOCATION (City, town, or county) (State) <b>Delmar, Del.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Monahan</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

7358

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1, 3, 5, 7, 244 7-2-59 et

CERTIFICATE OF DEATH

07347

Reg. Dist. No.

1. PLACE OF DEATH, a. COUNTY <i>Thames</i>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Thames</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>Life</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>At home</i>				d. STREET ADDRESS <i>1010</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Nicholas Martha E.</i>				4. DATE OF DEATH Month <i>6</i> Day <i>16</i> Year <i>1959</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Col</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1881</i>	
9. AGE (In years and day) <i>76</i> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Wisconsin</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Wm Jackson</i>				14. MOTHER'S MAIDEN NAME <i>Mary Clark</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <i>212-14 8894</i>		17. INFORMANT <i>Mary Michael</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) <i>Carcinomatous Peritoneal</i> <i>158X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <i>Artiriosclerotic Cardiovascular Disease</i> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Artiriosclerotic Cardiovascular Disease</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 2</i> 19 <i>59</i> to <i>6/16</i> 19 <i>59</i> , that I lost s/he the deceased on <i>6/7</i> 19 <i>59</i> , and that death occurred at <i>3:30</i> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Refus S. Gardner Jr</i> M.D.				ADDRESS (Street, city or town, state) <i>Pinebluff Rd. Salisbury, Md</i>			
PHYSICIAN'S NAME (Type) <i>REFUS S. GARDNER JR</i>				DATE SIGNED <i>6/16/59</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-21-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Greenlee</i>		22d. LOCATION (City, town, or county) (State) <i>Salisbury, Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Kraus</i>				24a. RECEIVED BY REGISTRAR DATE <i>JUN 25 1959</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



7359

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, residence before admission) a. STATE <u>N.J.</u> b. COUNTY <u>BURLINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MAPLE SHADE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>GENERAL Hospital</u>		d. STREET ADDRESS <u>219 W. CENTER AVE.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>Nicholson</u> Middle <u>Sr.</u> Last		4. DATE OF DEATH <u>JUNE 27</u> Month <u>27</u> Day <u>1959</u> Year	
5 SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-22-78</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u> Hours <u>1</u> Min <u>0</u>	IF UNDER 24 MRS. Months <u>8</u> Days <u>1</u> Hours <u>1</u> Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STOCKMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETAIL STORE</u>	11 BIRTHPLACE (State or foreign country) <u>ENGLAND</u>
12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>N/O</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>JOHN NICHOLSON JR.</u>		Address <u>555 FORKLAND AVE. MAPLE SHADE, N.J.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> (c) <u>?</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anthraco-silicosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/28</u> , 19 <u>59</u> , to <u>6/29</u> , 19 <u>59</u> , that I lost the deceased on <u>6/29</u> , 19 <u>59</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rufus S. Gardner Jr.</u>		ADDRESS (Street, city or town, state) <u>PINEBLUFF RD. 6/29/59</u>	
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER JR.</u>		<u>SALISBURY, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL. (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7/3/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>PENNSAUKEN N.J.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Sullivan</u>		ADDRESS <u>Salisbury Md</u>	
24a. REC'D BY REGISTRAR <u>JUL 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Colton &amp; Kane</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7360

CERTIFICATE OF DEATH

07349

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>1 1/2 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12. SALISBURY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>John B. Parsons Home</u>				d. STREET ADDRESS <u>1 Bush St.</u>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>Dennis</u> Last <u>PARKER</u>				4. DATE OF DEATH Month <u>6</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/13/1885</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min <u>13</u>		IF UNDER 24 HRS Months <u>13</u> Days <u>13</u> Hours <u>13</u> Min <u>13</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired House Matron</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>LAUNDRY</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Washington R. Dennis</u>				14. MOTHER'S MARRIED NAME <u>ROSANNA CLAYVILLE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Mrs. J. Walter Jackson, Pikesville, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> (b) <u>—</u> (c) <u>—</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1922</u> to <u>6/7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/7</u> , 19 <u>59</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Fred R. Gramse</u> M.D. <u>SALISBURY, MD</u>				DATE SIGNED <u>6/8/1959</u>			
PHYSICIAN'S NAME (Type) <u>Dr. Fred R. Gramse, SALISBURY, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Grace Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pittsville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson</u>				ADDRESS <u>SALISBURY, MARYLAND</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 15 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Normant. Baker</u>							



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

7361

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07350

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 20b to f. File - v-44 7/2/59

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury (Rural)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. Pen Gen. Hospital</b>		d. STREET ADDRESS <b>R.D.# 3 (Walston)</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GORMAN</b> Middle <b>EDWARD</b> Last <b>PARKER</b>		4. DATE OF DEATH Month <b>June</b> Day <b>28th</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 15, 1919</b>
9. AGE (In years last birthday) <b>40</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>13</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter - Construction</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>R.D.# 1 Salisbury, Md</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>George Edward Parker</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Brittingham</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W. II</b>	
17. INFORMANT <b>Mrs. Naomi H. Parker (Wife)</b>		R.D.# <b>3 (Walston)</b> <b>Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>fracture skull - fract. cervical vertebra</b> DUE TO <b>823X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Lost control of car on curve. Was thrown into field.</b>	
20c. TIME OF INJURY Month, Day, Year <b>10</b> hour a. m. <b>6/28</b> 19 <b>59</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Pemberton Drive</b>	20f. (City or town) (County) (State) <b>Salisbury Wicomico Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Philip A. Insley</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. Philip A. Insley</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 30/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery-Walston-R.D.#</b>	22d. LOCATION (City, town, or county) (State) <b>Salisbury, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR DATE <b>JUL 6 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Hanks</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

7362

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07351

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oriole</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hosp.</u>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Parks</u> Last <u>Parks</u>		4. DATE OF DEATH Month <u>6</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1907</u>
9. AGE (In years lost birthday) <u>51</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ML.</u>	
11 BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>Elisha Parks</u>		14. MOTHER'S MAIDEN NAME <u>Addie Laird</u>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16 SOCIAL SECURITY NO. <u>215-05-6246</u>	
INFORMANT <u>Clarence Muir</u> Address <u>Oriole, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>intense</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-15</u> , 19 <u>59</u> , to <u>6-24</u> , 19 <u>59</u> (that I last saw the deceased alive on <u>6-24</u> , 19 <u>59</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William S. Elks, Jr.</u> M.D.		DATE SIGNED <u>6-24-59</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/27/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oriole</u>		22d. LOCATION (City, town, or county) (State) <u>Oriole Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Dorman</u> ADDRESS <u>Prescott Ave Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 30 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

7376

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07352

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Wicomico</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Salisbury</b>		c LENGTH OF STAY IN 1b <b>X</b> <b>Salisbury (Rural)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.D.# 3 (At Home)</b>		e. STREET ADDRESS <b>R.D.# 3</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>RILEY</b> Last <b>PARSONS</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>20th</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED X X</b> <b>DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>July 17, 1864</b>
9. AGE (In years last birthday) <b>94</b> yrs		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>3</b>	11. IF UNDER 24 HRS Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	11. BIRTHPLACE (State or foreign country) <b>Pittsville, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>Jacob Parsons</b>		14. MOTHER'S MAIDEN NAME <b>Hettie (Unk)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Unk</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT Mrs. Tina Wilkins (Daughter) R.D.# 3 Salisbury, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>Coronary from Central Hemorrhage</b> DUE TO <b>Retinal Central Hemorrhage with R.P.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Arteriosclerosis</b> DUE TO <b></b> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>4</b> <b>2 yr</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 15, 1959</b> to <b>June 20, 1959</b> that I last saw the deceased alive on <b>June 19, 1959</b> and that death occurred at <b>12:15 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Delaware Ave. Delmar, Delaware</b>	
ACTUAL SIGNATURE <b>Dr. S. Howard Lynch</b> M.D. <b>June 22 /59</b>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Dr. S. Howard Lynch</b>		<b>Delaware Ave. Delmar, Delaware</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 23/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Charity Church Cemetery-Near Salisbury, Md.</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>JUN 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	





7377

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07353

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sharptown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sharptown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>School Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Clarence</b> Middle <b>Holland</b> Last <b>Phillips</b>		4. DATE OF DEATH Month <b>June</b> Day <b>8</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 5, 1886</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Bridge Operator for State of Md.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wicomico County, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Allison W. Phillips</b>		14. MOTHER'S MAIDEN NAME <b>Roxy Walker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Lena M. Phillips, Sharptown, Maryland</b>		Address	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO (b) <b>Arterio Sclerosis</b> DUE TO (c) <b>5 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 8, 1959</b> to <b>June 8, 1959</b> , that I last saw the deceased alive on <b>June 8, 1959</b> , and that death occurred at <b>1:50 AM</b> , from the causes and on the date stated above.		DATE SIGNED <b>6/11/59</b>	
ACTUAL SIGNATURE <b>A. S. Kuhlman</b> M.D.		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) <b>A. S. Kuhlman</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 11, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Riverton Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Riverton, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Frampton and Son, Federalsburg, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 12 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Howard</b>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7363

CERTIFICATE OF DEATH

07354

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pen Gen Hospital</b>		d. STREET ADDRESS <b>411 Barclay St</b>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>THOMAS</b> Last <b>POTTS</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>11</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 9, 1933</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>6</b> Days <b>2</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Painting</b>	
11. BIRTHPLACE (State or foreign country) <b>Centerville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>M. Fillmore Potts</b>		14. MOTHER'S MAIDEN NAME <b>Mary Stant</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO <b>INFORMANT</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro Vascular Accident</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute myocardial infarction</b> DUE TO (c) <b>Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <b>June</b> Day <b>9</b> Year <b>19 59</b> Hour <b>10</b> a. m. <b>30</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 9, 1959</b> to <b>June 11, 1959</b> that I last saw the deceased alive on <b>June 11, 1959</b> , and that death occurred at <b>10:30 P</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>June 12 1959</b>			
ACTUAL SIGNATURE <b>AC Mitchell</b> M.D.		June 12 1959	
PHYSICIAN'S NAME (Type) <b>Dr. O. J. Burton</b>		<b>Maryland Ave. Salisbury, Maryland</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jun. 14, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 15 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7364

CERTIFICATE OF DEATH

07355

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula Gen Hosp</u>		d. STREET ADDRESS <u>Route # 2</u>	
3. NAME OF DECEASED (Type or print) First <u>Amelia</u> Middle <u>Price</u> Last <u>Price</u>		4. DATE OF DEATH Month <u>6</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>Fm.</u>	6. COLOR OR RACE <u>AA.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-18-1886</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Midwife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>	
11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Emma Green</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>NO</u>	
17. INFORMANT <u>Mrs. Lydia Timmons, Powellville, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Labor Pneumonia, Rt Lower Lobe</u> 440 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 wks</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congenital Heart Disease, Valvular Decompensation</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/30</u> , 19 <u>59</u> , to <u>6/7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/6</u> , 19 <u>59</u> , and that death occurred at <u>2:55</u> A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rufus S. Gardner, Jr. M.D.</u>		ADDRESS (Street, city or town, state) <u>Pinebluff Rd Salisbury, Md.</u>	
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR</u>		DATE SIGNED <u>6/11/59</u>	
22a. BURIAL, CREMATION, REBURY (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6-10-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Taylor's Gate Cem</u>	22d. LOCATION (City, town, or county) (State) <u>NE, Snow Hill, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart</u>		ADDRESS <u>FUNERAL HOME, Salisbury, Md</u>	
24a. REC'D BY REGISTRAR <u>JUN 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate in a sealed envelope, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7378 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07356

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parsonsburg</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>In Village</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parsonsburg</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>In Village</b>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>HENRY</b> Last <b>QUILLEN</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>16th</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 3, 1873</b>
9. AGE (In years last birthday) <b>85 yrs.</b>		IF UNDER 1 YEAR Months <b>85</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Farmer-Chicken Grower</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Worcester Co. Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U S A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John J. Quillen</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Godfrey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk</b>		16. SOCIAL SECURITY NO. <b>(If yes, give year or dates of service)</b>	
17. INFORMANT <b>Mr John L. Quillen (Son)</b>		Address <b>Parsonsburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>(b)</b> DUE TO <b>(c)</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>p. m.</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Earl L. Rover</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. Earl L. Rover</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>June 17 /1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jun. 19, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>R.D.# Willards Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>DATE JUN 18 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	





may be returned to the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7365

CERTIFICATE OF DEATH

07357

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>1 WK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula Gen. Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elmer Woodland Smith</u>		4. DATE OF DEATH Month Day Year <u>June 4 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>5/12/1911</u>
9. AGE (In years last birthday) <u>48</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Farming</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Thomas J. Smith</u>	
14. MOTHER'S MAIDEN NAME <u>Ava May Washburn</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>	
16. SOCIAL SECURITY NO. <u>214-28-3434</u>		17. INFORMANT <u>Bilbert Smith - Salisbury, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> DUE TO (b) <u>Coronary Atherosclerosis Unknown</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>		20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>Salisbury</u>		(County) (State)	
21. I certify that I attended the deceased from <u>May 25 1959</u> to <u>June 4 1959</u> that I last saw the deceased alive on <u>June 4 1959</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>David J. Gilmore</u>		DATE SIGNED <u>June 4, 1959</u>	
PHYSICIAN'S NAME (Type) <u>David J. Gilmore</u>		<u>Medical Center, Salisbury, Md.</u>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/7/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wico. Mem. Park</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill &amp; Johnson Co</u>		ADDRESS <u>Salisbury, MD</u>	
24a. REC'D BY REGISTRAR <u>WUN 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 11-24-59 et

7366

CERTIFICATE OF DEATH

Reg. Dist. No. 07358

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Del.</u> b. COUNTY <u>Sussex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>Salisbury</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>		d. STREET ADDRESS <u>Salisbury</u>	
3. NAME OF DECEASED (Type or print) First <u>MAUDE</u> Middle <u>HANDY</u> Last <u>SMITH</u>		4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 27, 1913</u>
9. AGE (In years last birthday) <u>45</u> yrs	10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>	12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chicken</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S.</u>	
13. FATHER'S NAME <u>Levin Handy, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Lottie Lewis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>221-05-7245</u>	
17. INFORMANT <u>Frank Smith</u>		Address <u>Salisbury, Del.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular Accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardio-Vascular Disease</u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>19</u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>June 6, 1959</u> to <u>June 8, 1959</u> , that I lost saw the deceased alive on <u>June 8, 1959</u> , and that death occurred at <u>9:05 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas C. Nelson, M.D.</u>		ADDRESS (Street, city or town, state) <u>Pine Bluff Road Salisbury, Md.</u>	
DATE SIGNED <u>6/8/59</u>			
PHYSICIAN'S NAME (Type) <u>Thomas C. Nelson, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/12/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Long's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury - Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald James - Muller - Del.</u>		ADDRESS <u>  </u>	
24a. REC'D BY REGISTRAR <u>John 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. House</u>	



7367

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 6244 7/8/59 cap

CERTIFICATE OF DEATH

07359

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> <b>nor.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> <b>Snow Hill</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>John B. Parsons Home for the Aged</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary (Mamie)</b> Middle <b>Esther</b> Last <b>Spurrler</b>		4. DATE OF DEATH Month <b>June</b> Day <b>25th</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 7, 1874</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months <b>85</b> Days <b>85</b> Hours <b>85</b> Min <b>85</b>	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Snow Hill, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John James Hill</b>		14. MOTHER'S MAIDEN NAME <b>Esther A. Taylor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>RECORDS—John B. Parsons Home Salisbury, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>450.0</b> <b>Atherosclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>450.0</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>	
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19</b> WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/25/1959</b> to <b>6/26/1959</b> that I last saw the deceased alive on <b>6/25/1959</b> , and that death occurred at <b>4:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Fred R. Gramse</b>		DATE SIGNED <b>June 27/1959</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Fred R. Gramse</b>		ADDRESS <b>S. Division St. Salisbury, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jun. 29, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Whatcoat Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Snow Hill, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b> ADDRESS <b>SALISBURY MARYLAND</b>		24a. REC'D BY REGISTRAR <b>JUL 6 '59</b>	24b. REGISTRAR'S SIGNATURE <b>C. L. S. Knaus</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

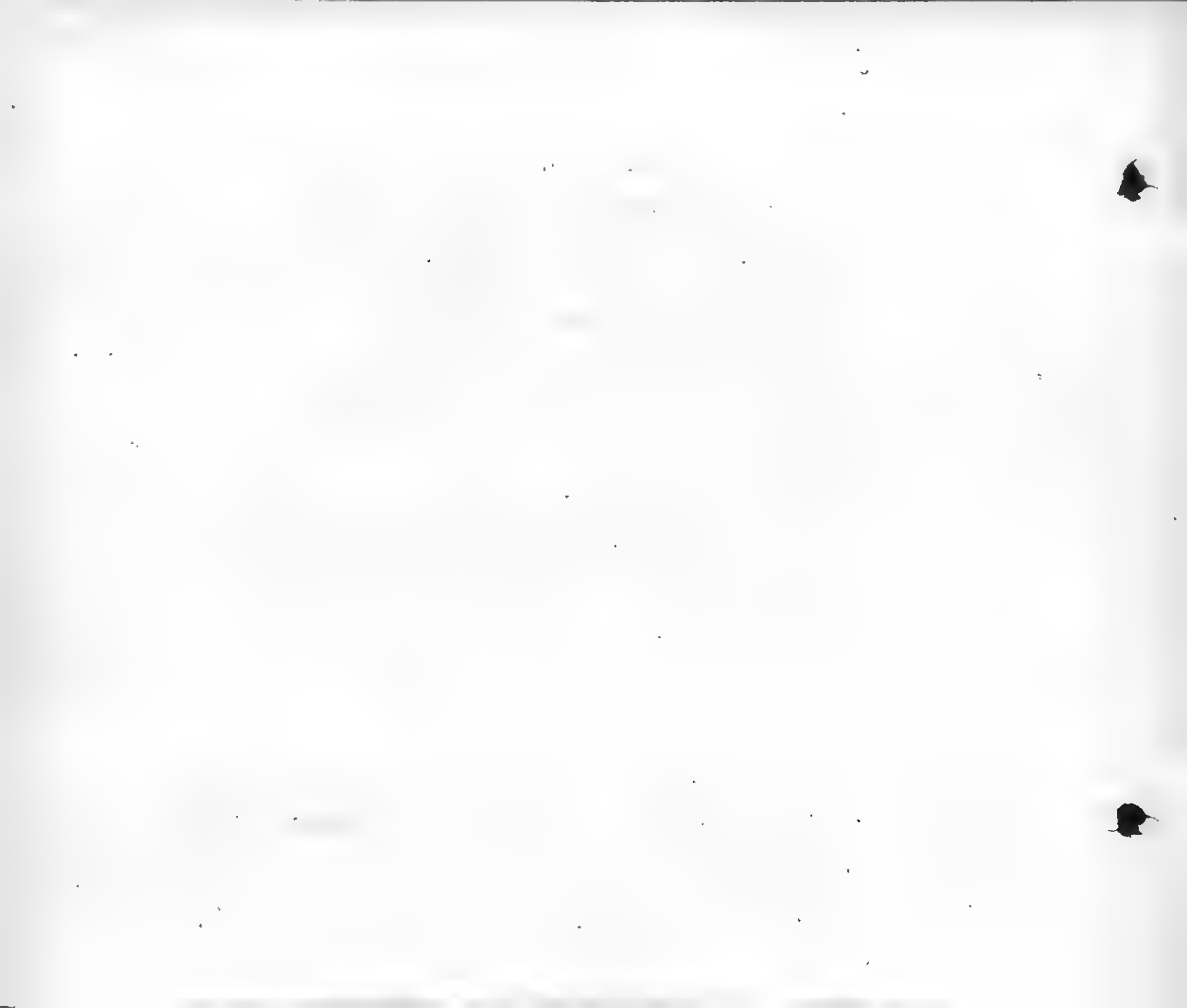
7368

CERTIFICATE OF DEATH

Reg. Dist. No.

07360

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>7 mos. 13da.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marion Station</b>		d. STREET ADDRESS -----	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Horace</b> Middle ----- Last <b>Thomas</b>		4. DATE OF DEATH Month <b>June</b> Day <b>27</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 3, 1902</b>
9. AGE (In years last birthday) <b>56 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Edward Thomas</b>		14. MOTHER'S MAIDEN NAME <b>Mary Johnson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>INFORMANT</b> Address <b>Hospital Records - Salisbury, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brochopneumonia, Left</b> <b>443X</b> DUE TO <b>n</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular Disease w/ Residual Left Hemiplegia and Motor Aphasia.</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL D SEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 Hours</b> <b>Years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/18/</b> 19 <b>58</b> , to <b>6/27/</b> 19 <b>59</b> that I last saw the deceased alive on <b>6/27/</b> 19 <b>59</b> , and that death occurred at <b>9:25A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G. Kosmahly</b> M.D.		ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b> DATE SIGNED <b>6/27/59</b>	
PHYSICIAN'S NAME (Type) <b>G. Kosmahly</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 30 59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Branch</b>		22d. LOCATION (City, town, or county) (State) <b>MARION SOM. Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles Howard</b>		24a. REC'D BY REG-STRAR DATE <b>JUN 30 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7369

## CERTIFICATE OF DEATH

07361

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>Life.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>S. H.</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Nathan</u> Middle <u></u> Last <u>Waters</u>				4. DATE OF DEATH Month <u>6</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>18 79</u>	
9. AGE (In years last birthday) <u>80</u> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>white white</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-18-5084</u>		17. INFORMANT <u>Eliyah Waters</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>Indefinite</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour <u></u> o. m. <u></u> p. m. <u></u> 19 <u></u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10 June 1959</u> to <u>18 June 1959</u> , that I last saw the deceased alive on <u>18 June 1959</u> , and that death occurred of <u>MI</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. A. Parnell, M.D.</u>				DATE SIGNED <u>Salisbury, Md. 19 June 1959</u>			
PHYSICIAN'S NAME (Type) <u>E. A. Parnell</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Buried</u>		<u>6-21-59</u>		<u>New Town Cem</u>		<u>New Town MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M. West</u>				ADDRESS <u>Salisbury, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 25 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carling E. Hines</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7370

CERTIFICATE OF DEATH

07362

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
c. LENGTH OF STAY IN 1b <u>5 days</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>B.</u> Last <u>Watson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 5 - 1884</u>	
9. AGE (In years last birthday) <u>74 7/28</u>		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>28</u>		10. IF UNDER 24 HRS Hours <u>7</u> Min. <u>28</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bay</u>				10. KIND OF BUSINESS OR INDUSTRY <u>Salisbury, MD</u>			
11. BIRTHPLACE (State or foreign country) <u>MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>MD</u>			
13. FATHER'S NAME <u>Robert Watson</u>				14. MOTHER'S MAIDEN NAME <u>Mary Powell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mary Watson, Salisbury, MD</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis, generalized</u>							
DUE TO <u>Coccyx fracture liver</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 30</u> , 19 <u>59</u> , to <u>June 3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 3</u> , 19 <u>59</u> , and that death occurred at <u>8:45 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William H. Fisher Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, MD</u>			
DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF <u>June 6/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baptist Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Salisbury, MD</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Sumner</u>				ADDRESS <u>Salisbury, MD</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Hines</u>	
DATE JUN 8 '59				24b. REGISTRAR'S SIGNATURE			



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7371

# CERTIFICATE OF DEATH

07363

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>6 Wks</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>12 Salisbury</b>				d. STREET ADDRESS <b>408 Lincoln Ave.,</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Peninsula General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>VIRGINIA ELIA WILLIAMS</b>			4. DATE OF DEATH Month Day Year <b>6 13 1959</b>				
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 16, 1872</b>		9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Archebold Morris</b>				14. MOTHER'S MAIDEN NAME <b>Mary Staton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Homer Littleton, Salisbury, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pericardial infarct of the Heart Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1949</b> to <b>6/13</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6/13/59</b> , 19 <b>59</b> , and that death occurred at <b>7:15 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>F. R. Gramse</b> M.D.				ADDRESS (Street, city or town, state) <b>Salisbury, Maryland</b>		DATE SIGNED <b>6/15/59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Fred R. Gramse South Division St., Salisbury, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/16/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Hill &amp; Johnson Co. Salisbury, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanes</b>	

*Norman F. Baker*

# CERTIFICATE OF DEATH

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Time of death

6. Place of death

7. Cause of death

8. Manner of death

9. Signature of physician

10. Signature of registrar

11. Signature of witness

12. Signature of informant

13. Date of registration

14. Place of registration

15. Signature of registrar

16. Signature of witness

17. Signature of informant

18. Signature of registrar

19. Signature of witness

20. Signature of informant

21. Date of registration

22. Place of registration

23. Signature of registrar

24. Signature of witness

25. Signature of informant

26. Signature of registrar

27. Signature of witness

28. Signature of informant

29. Signature of registrar

30. Signature of witness

31. Signature of informant

32. Signature of registrar

33. Signature of witness

34. Signature of informant

35. Signature of registrar

36. Signature of witness

37. Signature of informant

38. Signature of registrar

39. Signature of witness

40. Signature of informant

41. Signature of registrar

42. Signature of witness

43. Signature of informant

44. Signature of registrar

45. Signature of witness

46. Signature of informant

47. Signature of registrar

48. Signature of witness

49. Signature of informant

50. Signature of registrar

51. Signature of witness

52. Signature of informant

53. Signature of registrar

54. Signature of witness

55. Signature of informant

56. Signature of registrar

57. Signature of witness

58. Signature of informant

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7372

CERTIFICATE OF DEATH

07364

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>12</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>701 West Main Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>L.</u> Last <u>Winder</u>				4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 14, 1903</u>	
9. AGE (In years last birthday) <u>56</u> yrs		IF UNDER 1 YEAR: Months <u>5</u> Days <u>6</u>		IF UNDER 24 HRS: Hours <u>5</u> Min. <u>6</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Merchant</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>James Winder</u>				14. MOTHER'S MAIDEN NAME <u>Annie Wright</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>No.</u>			
17. INFORMANT <u>Allice Winder, 701 West Main Street</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage from Esophageal Varices</u> DUE TO <u>581.0</u>							
(b) <u>Cirrhosis of Liver</u> DUE TO <u>581.0</u>							
(c) <u>Underlying cause last.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>3 months</u> INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>16 March 1958</u> to <u>16 June 1959</u> , that I last saw the deceased alive on <u>10 June 1959</u> , and that death occurred at <u>10:15</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. A. FURNELL</u>				DATE SIGNED <u>15 June 59</u>			
PHYSICIAN'S NAME (Type) <u>E. A. FURNELL</u>				ADDRESS (Street, city or town, state) <u>157 W. Main Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>14 June 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenacre Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Wicomico Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart, Salisbury Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 17 '59</u>			
24b. REGISTRAR'S SIGNATURE <u>Clinton F. Stewart</u>							

CERTIFICATE OF DEATH

MAKALANG STATEMENT OF DEATH - JALAPONG 18

NAME

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

WITNESSES

SIGNATURE

DATE

PLACE

TIME

WITNESSES

SIGNATURE

DATE

PLACE

TIME

WITNESSES

SIGNATURE

DATE

PLACE

TIME

WITNESSES

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DATE

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TIME

WITNESSES

SIGNATURE

DATE

PLACE

TIME

WITNESSES

SIGNATURE